

ROADMAP TO THE IDEAL CRISIS SYSTEM

Group for the Advancement of Psychiatry
Committee on Psychiatry and the Community
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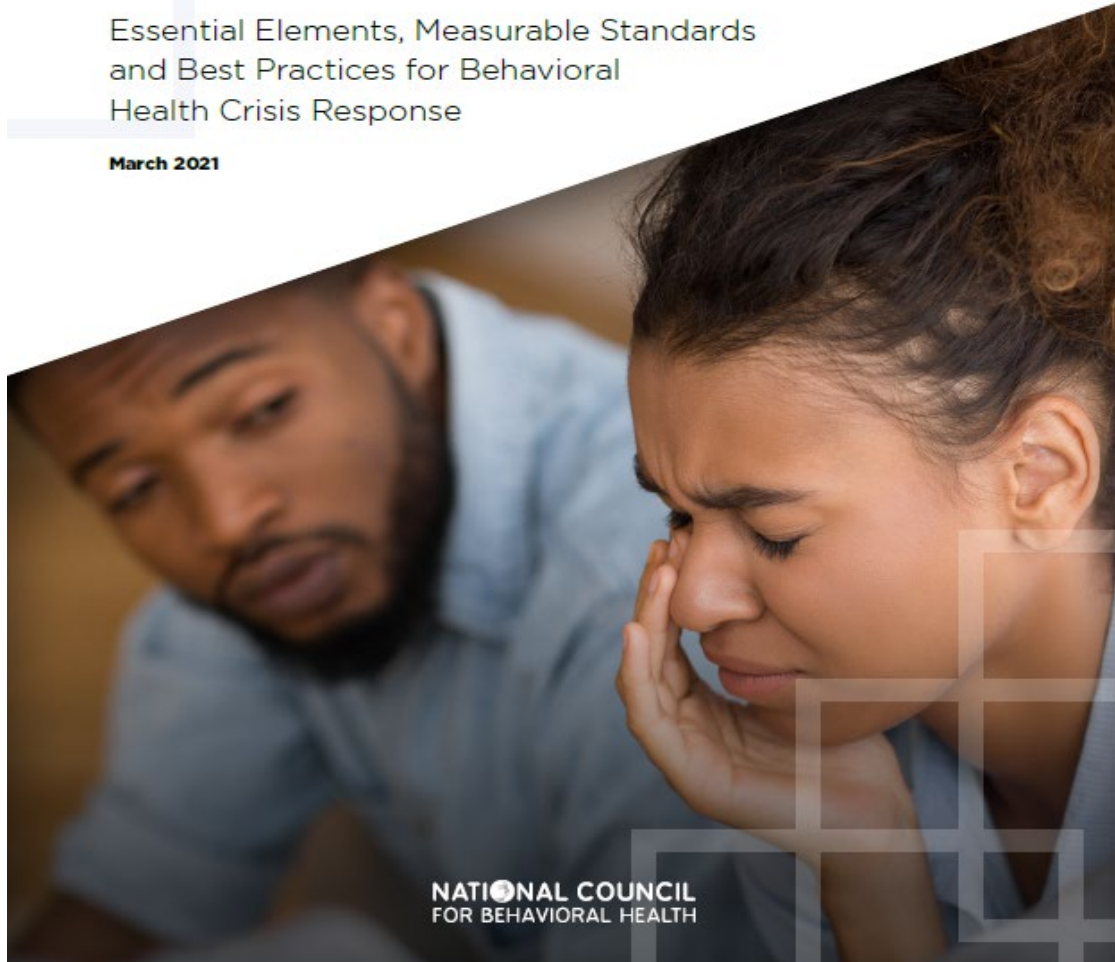


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PSYCHIATRY

ROADMAP TO THE IDEAL CRISIS SYSTEM

Essential Elements, Measurable Standards
and Best Practices for Behavioral
Health Crisis Response

March 2021



NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

A report of the Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry

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Vision

-Every individual/family in every community in the U.S. will have access to a continuum of best practice BH crisis services that are welcoming, person-centered, recovery-oriented, and continuous.

-An excellent Behavioral Health Crisis System is an essential community service, just like police, fire and emergency medical services (EMS).

-Every community should expect a highly effective BH crisis response system to meet the needs of its population.

-A BH crisis system is more than a single crisis program.

It is an organized set of structures, processes, and services that are in place to meet all types of urgent and emergent BH crisis needs in a defined population or community, effectively and efficiently.

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Guiding Principles and Values of an Ideal Crisis System

Ideal BH Crisis Systems are:

Based on a shared set of values.

Welcoming and engaging, customer-centered, hopeful, safe, compassionate, empowering, recovery-oriented, trauma informed, and culturally appropriate.

Accountable for all people and populations

Designed for the expectation of complexity

MH and SUD, plus I/DD, health, housing, criminal justice, child/adult protection, etc.

Designed to be clinically effective and cost effective

Able to use value-based involuntary intervention - only when necessary

Organized to share and use data for continuous improvement



READING THE REPORT

The report begins with an organizing framework that describes how to build an ideal crisis system that is “person-centered” and “customer-oriented”, inclusive of a foundational set of values and operational principles. (Link to Framework, Values, and Principles Chapter).

The report delineates how implementation of successful systems requires three interacting design elements, along with measurable indicators for the components of each. These three interacting design elements provide the structure for the three major sections of this report.

- Section I: Accountability and Finance
- Section II: Crisis Continuum: Basic Array of Capacities and Services
- Section III: Basic Clinical Practice



READING THE REPORT

The following provides a brief introduction to these three sections, along with key takeaways from each.



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Section I: Accountability And Finance

- An ideal behavioral health crisis system must have both a mechanism to finance and implement a comprehensive continuum of crisis services and a mechanism to ensure oversight, accountability, and quality of the performance of that continuum.
- This section defines the concept of an **Accountable Entity**, which is a structure and a mechanism for allocating responsibility and accountability that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population. There are numerous different models of these structures.



FINANCING



ELIGIBILITY (ALL-PAYER)



GEOGRAPHIC ACCESS AND NETWORK ADEQUACY



QUALITY METRICS



PERFORMANCE INCENTIVES



FLOW AND THROUGHPUT



COMPREHENSIVE CLIENT TRACKING DATA SYSTEM



FORMAL ASSESSMENT OF CUSTOMER SATISFACTION



STANDARDIZED UTILIZATION MANAGEMENT AND LEVEL OF CARE DETERMINATION



RELATIONSHIP TO THE REST OF THE SERVICE SYSTEM

Section I: Accountability And Finance – Key Takeaways

There is an entity accountable for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components and best practices.

There is a behavioral health crisis system coordinator and a formal community collaboration of funders, behavioral health providers, first responders, human service systems and service recipients.

There is a stated goal that each person and family will receive an effective, satisfactory response every time.

Geographic access is commensurate with that for EMS.

Multiple payers collaborate so that there is universal eligibility and access.

Section I: Accountability And Finance – Key Takeaways

There are multiple strategies for successfully financing community behavioral health crisis systems.

Service capacity of all components is commensurate to population need.

Individual services rates and overall funding are adequate to cover the cost of the services.

There is a mechanism for tracking customers, customer experience and performance.

There are shared data for performance improvement.

Quality standards are identified, formalized, measured and continuously monitored

Section II: Crisis Continuum: Basic Array Of Capacities And Services

An ideal behavioral health crisis system has:

- comprehensive array of service capacities,
 - a continuum of service components
 - adequate multi-disciplinary staffing
- to meet the needs of all segments of the population.



Section II: Crisis Continuum: Basic Array Of Capacities And Services

The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.

Family members and other natural supports, first responders and community service providers are priority customers and partners.

Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.

There is capacity for sharing information, managing flow and keeping track of people through the continuum.

There is a service continuum for all ages and people of all cultural backgrounds.

All services respond to the expectation of comorbidity and complexity.

Section II: Crisis Continuum: Basic Array Of Capacities And Services

Welcome all individuals with active substance use in all settings in the continuum.

Medical screening is widely available and is not burdensome.

There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.

Telehealth is provided for needed services not available in the local community.

Program components are adequately staffed by multidisciplinary teams, including peer support providers.

There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.

Section III: Basic Clinical Practice

An ideal behavioral health crisis system has guidelines for utilization of the best clinical practices for crisis intervention with associated processes for practice improvement and developing workforce competency.



**CORE COMPETENCIES FOR
ENGAGEMENT, ASSESSMENT
AND INTERVENTION**



**POPULATION-SPECIFIC
CLINICAL BEST PRACTICES**



**SCREENING AND
INTERVENTION TO PROMOTE
SAFETY**



**COLLABORATION,
COORDINATION AND
CONTINUITY OF CARE**



**PRACTICE GUIDELINES
FOR INTERVENTION AND
TREATMENT**

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Section III: Basic Clinical Practice

The system has expectations of universal competencies based on values. Welcoming, hope and safety come first.

Engagement and information sharing with collaterals is an essential competency.

Staff must know how to develop and utilize advance directives and crisis plans.

Essential competencies include formal suicide and violence risk screening and intervention.

“No force first” is a required standard of practice.

Risk screening guidelines for medical and substance use disorder (SUD)-related issues must facilitate rather than inhibit access to behavioral health crisis care.

Section III: Basic Clinical Practice Continued

Utilizing peer support in all crisis settings is a priority.

Behavioral health crisis settings can initiate medication-assisted treatment (MAT) for SUD.

Formal practice guidelines for the full array of ages and populations, including integrated treatment for mental health, SUD, cognitive and medical issues.

Utilize best practices for crisis intervention, like critical time intervention, to promote successful continuity and transition planning.



Tools to Help Implementation

Ten Steps for Communities

Ten Steps for System Leaders and Advocates

Six examples of successful crisis system local implementation

Community Behavioral Health Crisis System Report Card *-An instrument to assist communities to assess their current status on each of the elements of an “ideal crisis system,” and to help prioritize next steps.*

10 STEPS FOR COMMUNITIES

- 1. Identify and convene community partners:** Identify community stakeholders and potential partners who are interested in, or have a stake in, behavioral health crisis services within your community and develop a voluntary ad-hoc group for initial discussions. Remember to engage stakeholders and funding partners that represent the whole community, not just those who are indigent or funded by Medicaid. Behavioral health crisis systems are an essential community service for everyone.
- 2. Read and process relevant sections of the report:** Share this report with those stakeholders and ask them to read the Executive Summary and the Introduction. Have the stakeholders identify aspects of the report most relevant to them over a few sessions and have them present sections of the report to the group as a whole.
- 3. Develop a local vision:** Have the stakeholders develop an initial vision for an ideal behavioral health crisis system in your community. Do not be discouraged if you are far from that goal right now. Every community with an improved behavioral health crisis system had to start at the beginning and make progress over time.
- 4. Disseminate the vision:** Write down this vision with some initial action steps and actively share it with others.
- 5. Accountable entity:** Identify one or more entities that may serve as the accountable entity within your community. It could be county leadership, city leadership, a managed care organization or an existing community collaborative addressing jail diversion or suicide prevention.

6. **Planning and implementation team:** Identify a team of people to meet regularly on an ongoing basis to begin to plan the ideal behavioral health crisis system. This could be a new group under the accountable entity or a component of an existing collaboration. Do not hesitate to seek consultation or outside facilitation if needed at this step or any point along the way.
7. **Baseline self-assessment:** Using the measurable criteria in the report, rating each item from 1-5, have the planning team rate the current status of your behavioral health crisis system. No matter what you find, give yourselves a round of applause. See the Report Card to help organize this step. Use the Report Card as well to track your progress over time.
8. **Early wins:** Identify three to five improvement opportunities that the team can address early on, within available capacity and resources. Develop and implement a collaborative plan to begin to make progress in small steps on each item. Give yourselves another round of applause for making progress.
9. **Data and financing:** At the same time, members of the planning team begin to gather clinical and cost data on current system performance and identify potential local, state and federal funding opportunities. Do not worry that your initial data are not perfect or if you do not find all the funding you will eventually need. Every community makes progress in steps with slow improvement in data using initial seed funds to attract further funding as the vision of the crisis system takes shape.
10. **Comprehensive plan:** Keep meeting and working together. Over a period of time, using the data you have gathered, with consultation if needed, use this report for guidance to develop a comprehensive, collaborative plan for the design of an ideal behavioral health crisis system for your community. Identify a step-by-step approach so multiple partners can begin to work together to make progress over a period of year



10 STEPS FOR SYSTEM LEADERS AND ADVOCATES

- 1. Establish, articulate and communicate a systemwide vision of ideal behavioral health crisis systems for all:** The core of this vision is that behavioral health crisis systems are an essential community service that should be at least on par with the responsiveness of emergency and urgent medical care - every person gets the right response every time. Incorporate core values in the vision: welcoming, hopeful, trauma-informed, recovery-oriented, integrated and designed with the goal of eliminating disparities in response for those who are most vulnerable and marginalized.
- 2. Develop an implementation plan:** As part of the vision, articulate a 10-year plan for working collaboratively with all system intermediaries, funders and communities to make step-by-step progress toward achieving universal progress. Remember that implementing universal 911 response systems took a decade or more.
- 3. Disseminate this report as a guiding document:** Highlight the essential elements of the system and encourage development of a system-wide conversation to adopt the vision. Essential elements that might be highlighted for purposes of conversation include local accountability (accountable entities), all-payer financing, system performance metrics, crisis continuum (e.g., call center, mobile crisis, urgent care, crisis center, various types of crisis residential programs, intensive community crisis intervention), response to all ages and population groups, clinical/medical leadership, peer support and best practices for crisis intervention.
- 4. Perform baseline self-assessment:** Encourage communities to come together to perform a systemwide baseline assessment of the current behavioral health crisis system, using the Report Card to track progress across the system over the course of the 10-year plan.
- 5. Identify performance metrics:** Using this report, convene system stakeholders to identify the most important quality metrics for behavioral health crisis system performance that all system intermediaries should be accountable to achieve.



6. **Award planning and implementation grants:** Develop a process to award community crisis collaboratives grants (possibly matching grants) for planning and implementation. This can begin with a few pilot communities, then slowly disseminated to the whole system. Continually measure progress in all communities across the system, rewarding small steps forward over time.
7. **Create a framework for identifying and empowering accountable entities:** Identify mechanisms for regional and local accountability for crisis system performance. These could be based on regional intermediary system structures and/or on existing templates for delineating community accountability for EMS.
8. **Require all-funder participation:** Require all private and public behavioral health funders to contribute appropriately to the funding of the community behavioral health crisis system that serves the people covered by or affected by their funding. This includes all types of insurance plans.
9. **Require coverage of and adequate rates for all elements of the crisis continuum:** Identify clear definitions of the various components and services in the behavioral health crisis continuum and require that Medicaid and other funders reimburse for those services (e.g. urgent care centers, crisis centers, residential crisis services, mobile crisis, intensive community crisis intervention) at rates that at least cover costs. Medical urgent care and emergency services do not operate at a loss; neither should commensurate behavioral health crisis services.
10. **Incorporate best practice standards into system regulations:** This report provides guidance for regulations that address items such as no force first, advance directives, medical screening, integrated response to individuals with co-occurring mental health/substance use disorder and behavioral health/intellectual and developmental disabilities and so on.

Certified Community Behavioral Health Center (CCBHC)

*Great Potential Financing and Delivery Platform for the
Ideal Crisis System*

CCBHC Increases the Availability of Crisis Response

100% of CCBHCs offer crisis response services, with **51%** of them having newly added crisis services as a result of certification.

Required crisis activities: 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization

Common crisis response activities include:

- Partners with 911 to have relevant 911 calls screened and routed to CCBHC staff (17%)
- Mobile behavioral health team responds to relevant 911 calls instead of police/EMS (e.g. CAHOOTS or similar model) (19%)
- Behavioral health provider co-responds with police/EMS (e.g. clinician or peer embedded with first responders) (38%)
- Operates a crisis drop-in center or similar non-hospital facility for crisis stabilization (e.g. 23-hour observation) (36%)
- Coordinates with hospitals/emergency departments to support diversion from EDs and inpatient (78%)



Full Report https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56

Executive Summary https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031221_GAP_Crisis-Report_ExecutiveSummary-final.pdf?daf=375ateTbd56